U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 06Nov2001

Case No.: 2000-LHC-00140

OWCP No.: 07-141740

IN THE MATTER OF

KATHERINE POMPA,
Claimant

v.

INGALLS SHIPBUILDING, INC.,
Employer

APPEARANCES:

GEORGE SHADDOCK, ESQ.
On Behalf of the Claimant

PAUL B. HOWELL, ESQ.
On Behalf of the Employer/Carrier

Before: RICHARD D. MILLS
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This is a claim for benefits under the Longshore and Harbor Workers' Compensation Act (the Act), 33 U.S.C. § 901, *et seq.*, brought by Katherine Pompa (Claimant) against Ingalls Shipbuilding, Inc. (Employer). The issues raised by the parties could not be resolved administratively, and the matter was referred to the Office of Administrative Law Judges for a formal hearing. The hearing was held on June 8, 2001 in Gulfport Mississippi.

At the hearing all parties were afforded the opportunity to adduce testimony, offer documentary evidence, and submit post-hearing briefs in support of their positions. Claimant testified and introduced one exhibit, post hearing, of Claimant's treatment records at Singing River Hospital, which was admitted.[1] Employer introduced thirty-three exhibits which were admitted including various applications for employment filled out by Claimant; Employer's Accident Report; Notice of Suspension of Compensation; Notice of Controversion; various medical records; Claimant's deposition; answers to interrogatories; and a vocational rehabilitation report.

A post-hearing brief was filed by Employer. Based upon the stipulations of the parties, the evidence introduced, my observation of the witness demeanor and the arguments presented, I make the following Findings of Fact, Conclusions of Law, and Order.

I. STIPULATIONS

At the commencement of the hearing the parties stipulated and I find:

1. Jurisdiction is proper under the Act;

2. Claimant suffered an injury or accident on October 10, 1996;

3. Claimant was injured in the course and scope of her employment;

4. An employer - employee relationship existed at the time of the accident;

5. Employer was first advised of the injury on October 21, 1996;

6. Employer filed a Notice of Controversion on October 30, 1996;

7. An informal conference was held on August 27, 1999;

8. Claimant's average weekly wage at the time of the injury was $366.52;

9. Temporary Total Disability benefits were paid from 10/23/96 to 10/23/96, and from 10/28/96 to 1/19/97 at a disability compensation rate of $244.34 per week for a total payment of $2,966.99;

10. Employer paid medical benefits for Claimant's shoulder only.

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[1] References to the transcript and exhibits are as follows: Hearing transcript- Tr.__; Claimant's exhibits- CX-__, p.__; Employer exhibits- EX-__, p.__; Joint Exhibits - JX - __; Br. - Brief.

II. ISSUES

The following unresolved issues were presented by the parties:

1. Causation of lumbar and psychiatric conditions;

2. Date of maximum medical improvement;

3. Nature and extent of Claimant's disability;

4. Medical benefits;

5. Attorney's fees.

III. STATEMENT OF THE CASE

A. Chronology

Claimant worked as a joiner/insulator for Employer; a position that entailed constructing the molding, doors, cabinets, and fixtures aboard ships as well as insulating the bulkheads and ducts. (Tr. 23). Claimant was injured while working for Employer on October 10, 1996, when she fell while stepping across false decking. (Tr. 23-25). The Employer was not informed of the accident until October 21, 1996, and the accident did not cause Claimant to lose any time from work until October 23, 1996. (EX 3). When describing the accident, Claimant related that she had injured her shoulder on some angle iron. *Id*. Claimant visited Employer's infirmary on October 21, 1996, where she complained of left shoulder pain. (EX 12, p.1). At the infirmary Claimant received x-rays, prescription medication and a sauna. (Tr. 26). She was released to return to work on October 24, 1996, with limited light duty restrictions. (EX 12, p. 2,5).

Shortly afterwards, on October 25, 1996, Claimant was laid off by Employer due to a lack of work. (EX 17, p.1). Employer voluntarily paid temporary total compensation pursuant to Claimant's shoulder injury beginning on October 28, 1996, (EX 6), but, controverted the claim on October 30, 1996. (EX 9). On November 20, 1996, Employer sent Claimant to see Dr. Hudson in relation to continuing pain from her injury, a visit that Claimant denies ever having taken place. (Tr. 27; EX 13). That visit was the first recorded time that Claimant complained about low back pain. (EX 13). Nonetheless, Dr. Hudson only diagnosed a muscular injury to the left shoulder. *Id*.

After having a conflict with Dr. Hudson in some way, (EX 14, p.2), Employer authorized Claimant to see Dr. Rutledge, Jr., an orthopaedic surgeon, to whom she complained of neck, shoulder and back pain. (Tr. 82; EX 14). On December 6, 1996, Dr. Rutledge opined that x-rays of her cervical and lumbar

spine were within normal limits, with no abnormalities, and diagnosed a contusion to her left shoulder with soft tissue injury. (EX 14, p.5). In regards to her back, Dr. Rutledge stated that it was possible that Claimant sustained a lumbosacral sprain with contusion, but, he did not relate this to her work-place accident. *Id*. On December 13, 1996, Claimant returned to Dr. Rutledge about back pain and he informed her that her pain was merely from a sprain, and that the more active she was, the faster it would clear. *Id*. at 6. On January 20, 1997, Dr. Rutledge released Claimant as physically capable of performing normal duties. (EX 14, p.8). In an amended notice of Controversion on January 31, 1997, Employer stated that there were no objective findings to substantiate ongoing loss of time. (EX 9, p.3).

Claimant continued treatment with Dr. Rutledge, visiting him periodically with reports of pain and numbness. (EX 14). On February 14, 1997, Claimant had an MRI which showed mild degenerative changes at L5-S1 disk, but no disc herniation or neural impairment. *Id*. at 11. By August 1997, Dr. Rutledge welcomed a second opinion to explain Claimant's continued reports of pain. *Id*. at 12.

On October 27, 1997, Claimant underwent a physical exam for Employer in an application for re-employment, where she indicated that she had an injury in 1996 but had been released by her doctor, and Claimant never related that she had any problems with her back. (EX 15, p.1). On October 29, 1997 Claimant returned to Employer to work as a pipe-fitter. (EX 33, p.29, EX 1, p.11). Based off Claimant's subjective complaints of pain, Dr. Rutledge issued a work restriction of no lifting over twenty five pounds on November 20, 1997. (EX 14, p.14). Claimant returned to Dr. Rutledge on November 25, 1997, but, Dr. Rutledge was unable to find anything wrong. *Id*. p. 17.

In April 1998, Claimant's son died in an automobile accident. (Tr. 31). Shortly thereafter, Employer called Claimant back to work where Claimant passed another physical exam. (EX 15, p.3-5). Claimant took as much as two months off work to cope with the loss of her son. (Tr. 33). On June 10, 1998, Claimant saw Dr. Westbrook who diagnosed Claimant with hypertension. (EX 18, p.1). Also, on August 31, 1998, Claimant again saw Dr. Rutledge with back pain complaints. (EX 14, p.17). On September 25, 1998, Claimant again saw Dr. Westbrook who diagnosed her as having severe depression, anxiety and coping difficulties. (EX 18, p.4). On October 21, 1998, Claimant was automatically terminated by Employer for failure to provide a medical excuse for taking time of work within seven days. (Tr. 105). On January 6, 1999, Dr. Westbrook, after treating Claimant for hypertension, depression and grief, released Claimant to return to work. (EX 18, p.12).

Subsequently, Claimant worked for Freide Goldman Offshore as a material control clerk from February 19, 1999 to May 21, 1999. (EX 20). At a work capacity evaluation, however, Claimant stated that she had never had any problems with her back. (EX. 20, p.11). Freide Goldman terminated Claimant for poor attendance, but, noted that she was able to perform her job well. (EX 20, p.2).

On June 16, 1999, after a referral from Dr. Westbrook, Claimant underwent treatment with Dr. McCloskey, who noted Claimant's subjective complaints of pain, and diagnosed post-traumatic low back syndrome, with a degenerative and bulging L5 disc. (EX 21, p.2). Dr. McCloskey scheduled an MRI

on August 4, 1999 which indicated a small central protrusion of the L5-S1 disk and minimal spinal stenosis, and by January 10, 2000 indicated that there were no neurological problems. *Id*. at 4-8. Dr. McCloskey referred Claimant to Dr. Chen for pain management. *Id*. at 7. On November 19, 1999, Dr. Chen recommended physical therapy three times a week for six weeks. (EX 22, p.2).

In July 2000, Claimant worked briefly for Ocean View Aquarium Products, Inc., where she constructed aquariums. (Tr. 123-24). On July 7, 2000 Claimant went to work for Lowe's, a home improvement store, in the plumbing department. (Tr. 124). Once again, Claimant denied ever having physical or mental limitations that would keep her from performing her job. (EX 33, p.1). Claimant quit this job on July 18, 2000, because she was unable to push metal ladders or move heavy goods. (Tr. 126-27).

After the death of her son in April 1998, Claimant began to experience severe depression, anxiety and coping difficulties. (EX 18, p.4). In January 1999, Dr. Westbrook, released Claimant from her psychological disabilities to return to work. (EX 18, p.12). On July 1, 1999, Claimant visited her sons grave, became emotionally unstable, overdosed on prescription medication in a suicide attempt, and underwent psychiatric hospitalization. (EX 19, p.9; EX 24-25). Claimant first went to Singing River Hospital where she was treated for a drug overdose and Dr. Whitlock diagnosed her as having severe depression. (EX 19, p.7). A urine drug screen was positive for amphetamines, benzodiazepines and marijuana. *Id*. at 10. Claimant was discharged on July 2, 1999. *Id*. at 13.

Again, on February 15, 2000, upon a mental writ issued by the Jackson County Mississippi Chancery Court, on the bequest of Claimant's daughter, Claimant was hospitalized in the Singing River Hospital Psychiatric Unit after threatening to kill herself. (EX 23, p.1). Claimant tested positive for controlled dangerous substances. *Id*. at 3. Dr. Roy Deal, Claimant's psychiatrist, diagnosed chronic dysthymia, personality disorder, and borderline antisocial and narcissistic traits. *Id*. at 2. On February 23, 2000, Claimant was discharged from Singing River Hospital, but, pursuant to court order, was on the waiting list for admission into State Hospital. *Id*. at 6.

On February 28, 2000, Claimant was admitted into State Hospital where she related that the reason for her admission was depression over the loss of her son in 1998, depression over the separation with her third husband and depression from living with her elderly father. (EX 25, p.5). Claimant was discharged on May 24, 2000 as having major depression with psychotic features. *Id*. at 65. Claimant continued treatment under Dr. Tracy for her depression. (EX 28).

At hearing, Claimant argued that her October 10, 1996, work-place injury was the cause of her back problems, which in turn, caused Claimant to become addicted to pain killers resulting in eventual hospitalization for psychological problems.(Tr.10-11). Claimant, however, had a long history for back related injuries and drug dependency. On July 11, 1975, Claimant sustained an injury to her back while stacking beverages and was taken to the emergency room at Singing River Hospital. (EX 11, p.1). An x-ray did not reveal any fracture or dislocation, but, it did reveal that there was slight narrowing of the disc

space at L5-S1. *Id*. Also on July 14, 1992, Claimant was working for BOH Brothers taking grating off the I-10 bridge over the Pascagoula Rive in Mississippi. Claimant was on a skiff below where workers were dropping down pieces of plywood for loading onto a Boston Whaler. As Claimant engaged in these activities she developed a pain in her back which radiated into her thighs. *Id*. at 44. Claimant was diagnosed with back strain was released back to work. *Id*. at 45. Claimant's pain, however, did not abate, and an MRI was taken which revealed a "moderate decreased signal from the L5," showing "moderate descessation and mild bulging of its annulus." *Id*. at 47. Additionally, in October 1994, Claimant went to the emergency room after hurting her back wrestling with her boyfriend, which a doctor diagnosed as low back strain. *Id*. at 50.

On October 15, 1981, a psychiatrist at Singing River hospital, Dr. Tracy, diagnosed Claimant with passive aggressive personality. (EX 11, p.6). Dr. Tracy also noted that Claimant was having suicidal thoughts, and suffered from anxiety and depression. *Id*. at 9. Also, on November 7, 1985, Claimant went to the hospital for treatment of depression, but left the hospital eight hours after being admitted. *Id*. at 18-20. Again, on March 5, 1987, Claimant was admitted to Singing River complaining of depression and anxiety in relation to divorce, a sexually abused daughter, financial straits and friction with her mother. *Id*. at 25. In an admission note on July 8, 1987, her doctor noted that her abuse of drugs was iatrogenic, and that Claimant was often in a drug stupor, to the point that Claimant could not navigate, although Claimant herself was oblivious to this fact and in denial. *Id*. at 35.

B. Claimant's Testimony

Claimant recounted her work history, facts of her workplace injury, and the medical treatment received for that injury. Claimant testified that her job with Employer was a joiner/insulator entailed repetitive climbing bending stooping and kneeling. (Tr. 23). In regards to her injury, Claimant stated that when she fell her shoulder hit some angle iron, and when she hit the steel deck of the ship, she landed "straight on [her] butt." (Tr. 25). Claimant testified that she immediately suffered back and shoulder pain. *Id*. Claimant admitted that Employer's accident report did not state that she injured her back, but explained that omission on the fact that the accident report was untrue, and that her back pain became more severe as time went on. (Tr. 77-78). Although Claimant signed the accident report, she did not fill it out, and she stated that the infirmary had prescribed strong pain medication. (Tr. 79-80). Also, Claimant explained why Dr. Rutledge's report of December 6, 1996 stated that her back pain did not begin until a few days after the accident by relating that her back pain became more severe as time went on, thus, Dr. Rutledge's report was not accurate, and she explained that Dr. Rutledge's conclusion that her back injury was not work related was influenced by information given to him by Employer. (Tr. 82-84). Claimant also stated that she was not going to admit to any drug abuse, mental or physical illnesses in any work-related physical because she needed to work. (Tr. 87-88). She denied having back problems even though she stated that the back pain is so intense that she would be "crying" by the end of every day. (EX 14, p.4). Currently, Claimant receives injections in her back for her pain. (Tr. 56). Claimant also takes the pain killer Darvocet, Relafen for inflammation, Celebrex depending on the weather, and has access to stronger prescription medications. (Tr. 53-54).

Regarding prior back injuries, Claimant testified that she did not remember the 1975 injury to her low back until the day of the hearing. (Tr. 70). Accordingly, claimant neither told any of her post-injury treating doctors of the earlier injury, nor related that injury on any application for employment . (Tr. 71). Claimant also stated that she could not remember if she had to take any time off work or if she was paid any compensation for that injury. *Id*. Claimant did remember, however, a workers' compensation claim with BOH Brothers from her 1992 back injury and acknowledged that she omitted to relate this information to her current treating physicians and lied when asked about prior back problems on employment applications, explaining that the injury was only "a pulled muscle." (Tr. 72). Similarly, Claimant stated that she did not remember obtaining an MRI in 1992 showing the same bulging of the L5-S1 disc that the MRI's taken after her 1996 injury revealed. (Tr. 74). Likewise Claimant testified that she did not remember receiving a low back injury from wrestling with the boyfriend in 1994. (Tr. 100-01).

Claimant also testified regarding her psychological injuries. In 1981 Claimant related that she saw Dr. Tracy for professional help in going through a divorce. (Tr. 91-92). Regarding psychological treatment in 1985, Claimant again testified that it was in relation to a divorce and acknowledged that she was on prescription medication and that she had requested more for herself. (Tr. 96). When confronted with hospitalizations in March and July of 1987, Claimant admitted being at the hospital but denied that she had threatened to commit suicide and reluctantly admitted having conflicts with her daughter concerning her lifestyle. (Tr. 97-99). On cross-examination Claimant admitted that she never sought psychological help from the time of her injury on October 10, 1996, until after her son's death in April, 1998, and that she did not remember her private health insurer paying for her psychological treatment bills or that her doctor had told the insurance company that the psychological injury was not work related. (Tr. 101-03).

Claimant's first attempt at suicide after her 1996 workplace accident occurred over a year after her son's death. (Tr. 45-46). Claimant testified that she had a prescription of Xanax nerve pills and left over from when her son died, and that she became depressed when visiting cemetery. (Tr. 46). After taking four Xantax, while she was also on the pain medication Darvocet, Claimant and was taken to the hospital. *Id*. When Claimant entered a mental hospital in February 2000, she testified that her admission was an agreement between her children, a court, and herself. (Tr. 47-48). At that time Claimant was addicted to pain medication and wanted to quit being a burden on her family and quit being a welfare recipient. (Tr. 48-49).

Regarding employment subsequent to her workplace injury in 1996, Claimant testified that she was re-employed by Employer after her son's accident in April 1998, and was automatically terminated in October 1998 for the failure to obtain a timely report excusing absenteeism. (Tr. 37). Claimant did not work again until February 1999, when she started her employment with Friede Goldman. (Tr.40). Claimant testified that she was terminated by Friede Goldman for poor attendance because she was having to abuse pain medication to work, but, she had to go to work because she was separated from her husband and needed the income. (Tr. 42). Claimant did not relate to Friede Goldman her prior back injuries because she knew that if she told the truth she would not be hired. (Tr. 116). Additionally, Claimant testified that she never reported any problems with her back or relating to her medical condition on an

employment physical because she stated that she thought that she only had to list hospitalizations that were associated with surgery. (Tr. 88). Also, Claimant testified that she worked for a subcontractor of Hiller Systems for a time but quit because it was too far to drive, she was having pain in her back, and the job required her to climb ladders. (Tr. 110). Likewise, Claimant testified that she quit working at Lowe's in July 2000, because she had problems with her back, was unable to move heavy inventory, and the job required her to stay on her feet. (Tr. 51).

C. Employer's Exhibits

C(1) Medical Records RE: Pre-Existing Condition

Employer introduced various medical records from 1975 to 1996 detailing previous mental and physical conditions of Claimant. On September 10, 1975, Dr. Enger issued a narrative of Claimant's treatment after injuring her back lifting beverages for Autrey Greer & Sons, Inc. (EX 11, p.1). He related that: Claimant was injured on July 11, 1975; taken to the emergency room on July 15, 1975, with complaints of low back pain; and was treated again on August 24, 1975 after Claimant alleged that she was not improving. *Id*. A physical examination revealed that hyperextension caused her some difficulty, and Claimant was treated with oral medication. *Id*. On September 2, 1975, Claimant came back to Dr. Enger, who noted no change in a physical examination, but, noted that a x-ray revealed slight narrowing of the disc space at L5-S1. *Id*. Dr. Enger, however, found very little wrong and felt that Claimant could return to work. *Id*.

A consultation report by psychiatrist Dr. Else Tracy dated October 10, 1981, revealed that Claimant was "anxious and felt to be depressed and apparently [had] been having suicidal thoughts." *Id*. at 9. Claimant was treated for personal, marital and family difficulties, and Dr. Tracy thought that Claimant may have a personality disorder or an underlying thought disorder. *Id*. Also, on November 7, 1985, Dr. Nicholls opined that Claimant suffered from depression, *Id*. at 19, and on March 5, 1987 Claimant was admitted to the hospital with severe depression and anxiety in relation to family and financial difficulties. *Id*. at 33. Clamant's mental state did not improve and Claimant was again hospitalized and treated by Dr. Tracy on July, 1987, after she threatened to commit suicide. *Id*. at 35. Dr. Tracy also noted a strong tendency to abuse medicines and alcohol with her drug abuse being iatrogenic. *Id*. Furthermore, Dr. Tracy opined that Claimant had difficulty accepting responsibility for her own behavior. *Id*. at 36.

On July 17, 1992, Dr. Enger issued a consultative report regarding Claimant's 1992 back injury with BOH Brothers. A physical examination revealed a slight prominence of the right paravertebral muscle but not a true spasm. *Id*. at 45. Again Claimant had difficulty with hyperextension, and Claimant complained of pain when rolling her legs. *Id*. A routine x-ray was normal and Dr. Enger released Claimant to return to work with minor restrictions. *Id*. A few weeks later, however, Claimant returned with complaints of low back pain and an MRI showed that the L5 disc had moderate desiccation and mild bulging, but, no actual disc herniation or complication was present. *Id*. at 46-47.

On October 3, 1994, Dr. McDowell also treated Claimant for low back pain that arose when Claimant was wrestling with her boyfriend. *Id*. at 50. Dr. McDowell diagnosed low back strain and prescribed pain medication, and indicated that she should feel better within three days.

C(2) Medical Records of Dr. Hudson

Dr. Hudson treated Claimant on November 20, 1996, over a month after her workplace accident. (EX 13, p.1). Claimant complained to Dr. Hudson about low back pain, but, Dr. Hudson did not take any x-rays and he only diagnosed Claimant with a muscular injury to her left shoulder. *Id*. In a letter dated September 27, 2000, Dr. Hudson related, after reviewing records from Drs. McCloskey, Chen, Rutledge and Westbrook, that:

> [It] is my opinion, to a reasonable medical probability that she does not have any permanent impairment or work restrictions due to her left shoulder injury. Based purely upon my record review, including my own records, I am not in a position to say beyond a reasonable medical probability that her back condition is not related to her employment injury. Recognizing that I saw her five weeks after her alleged injury makes that difficult, the fact that it is not mentioned in her initial encounter notes at the Ingalls yard hospital certainly does suggest that she does not have immediate low back pain and would make it less likely that her back pain is related to her alleged injury though.

Id. at 2.

C(3) Medical Records of Guy Rutledge

On December 6, 1996, Claimant began treatment with Dr. Rutledge. (EX 14, p.2). Claimant told Dr. Rutledge that her low back pain started a few days after her accident, worse on the left side than on the right. *Id*. A physical exam showed hyperextension was "uncomfortable" and tenderness in the L5-S1 interspinous ligament as well as the superior gluteal nerve. *Id*. at 3. Dr. Rutledge further opined that it was possible that Claimant sustained a "lumbosacral sprain with a contusion; however, it would be extremely unusual to have sustained a significant back injury with no mention of back pain for a period of two weeks after her injury." *Id*. Dr. Rutledge did not specifically connect the injury with her fall. *Id*. On December 9, 1996, Claimant came back complaining of massive pain and received a prescription of Darvocet.

On December 13, 1996, Dr. Rutledge informed Claimant that there was no reason for her back to hurt, that she just had a sprain, and told her that the more active she was the faster it would clear. *Id*. On January 28, 1997, Claimant came to Dr. Rutledge with complaining of numbness in the right arm and leg. *Id*. at 7. Dr. Rutledge explained that such pains were not related to her back injury, were imaginary in origin, and noted that she had "a lot of weird ideas about her back." *Id*. Claimant returned on February 7, 1997 with continuing complaints of back pain. *Id*. at 11. Dr. Rutledge, however, could not find anything more than a lumboscral sprain. *Id*. Nonetheless, he scheduled an MRI which reveled mild degenerative

changes at the L5-S1 disc without herniation or neural impairment. *Id*. A copy was given to Claimant and Dr. Rutledge told her that she just needed to get over the back pain by increasing her activity. *Id*. By August 1997, Dr. Rutledge opined that Claimant did not have anything of significance, but, welcomed a second opinion. *Id*. at 12.

C(4) Medical Records of Dr. Westbrook

On October 21, 1998, Claimant visited Dr. Westbrook about continued depression due to the loss of her son, marital, financial, and job related problems. (EX 18, p.5). Dr. Westbrook diagnosed severe depression, anxiety and coping difficulties. *Id*. at 4. Claimant's depression was such that Dr. Westbrook considered her totally disabled. *Id*. at 9. On March 9, 1999, Claimant complained of low back pain , but a physical examination revealed no problems. *Id*. at 14. Nonetheless, Dr. Westbrook prescribed pain medication. *Id*. On April 7, 1999 and May 3, 1999, Claimant came back to Dr. Westbrook concerned with low back pain and was prescribed more medication. *Id*. at 15.

On May 3, 2000, Dr. Westbrook ordered another physical test regarding Claimant's back pain. *Id*. at 19. The test revealed lumbar flexation was limited to 90% of full range of motion and lumbar extension was limited to 75%. *Id*. Also, Claimant had a "pelvic movement dysfunction with a restrictive barrier into right innominate posterior translation and a hypomobility noted at L4-5 with active movements." *Id*. Treatment consisted of energy mobilization, heat and postural education. *Id*. at 20.

C(5) Medical Records of John McCloskey

Dr. McCloskey first treated Claimant on June 16, 1999 in relation to, *inter alia*, intermittent severe low back pain. (EX 21, p.1). Dr. McCloskey noted that an MRI showed degenerative bulging at the L5 disc, and that a bone scan performed by Dr. Rutledge was unremarkable. *Id*. A physical exam revealed that Claimant could bend symmetrically at the waist and that there was some tenderness in the region of the SI joints bilaterally. *Id*. Dr. McCloskey diagnosed chronic post-traumatic low back syndrome with a degenerative and bulging L5 disc and gave various pain medication prescriptions. *Id*. at 2. An August 1999 MRI of Claimant's pelvis and hips came back as reading normal and an MRI of the lumbar spine produced a small central protrusion of the L5-S1 disc with minimal spinal stenosis but with no root compromise. *Id*. at 4.

By a letter, dated August 7, 1999, Dr. McCloskey related to Claimant that he was unsure that the medication he prescribed would help at all, and recommended that, if Claimant wanted to pursue her problems further, she should see another doctor. *Id*. at 6. On September 1, 1999, Claimant again contacted Dr. McCloskey seeking more pain medication. *Id*. at 7. When asked if he could related Claimant's back injury to her work in 1996, Dr. McCloskey deferred judgment to Dr. Rutledge. *Id*. at 8. On April 4, 2001, Dr. McCloskey was shown prior medical records from Dr. Enger in relation to her 1975 and 1992 back injuries. *Id*. at 10. Dr. McCloskey noted that the MRI scan from 1992, when compared with his MRI scan in 1999, were virtually identical. *Id*. Also, with the benefit of Claimant's medical reports

prepared soon after Claimant's 1996 injury, Dr. McCloskey stated that he "could not causally relate Claimant's back pain to the employment injury of October 10, 1996, based upon a reasonable medical probability." *Id*.

C(6) Medical Reports of Dr. Deal

On February 15, 2000, Claimant began treatment with Dr. Deal, a psychiatrist, after being admitted to the hospital on a mental writ by the Jackson County Mississippi Chancery Court because she was threatening to commit suicide. (EX 23, p.1). Causes for Claimant's admittance were that: her daughter does not show enough interest in her; drug abuse which Claimant denied; and marital discord. *Id*. Dr. Deal's diagnostic impression was chronic dysthymia, personality disorder with borderline antisocial and narcissistic traits. *Id*. at 2. On a drug test, Claimant tested positive for benzodiazepine and cannabinoids. *Id*. at 3. On the date Dr. Deal discharged Claimant he noted that she was in strong denial about the extent of her chemical dependancy problem, and was accepting very little responsibility for her problems, behavior and the related consequences. *Id*. at 7.

C(7) Medical Records of Dr. Tracy

On June 14, 2000, Claimant again came under the care of Dr. Tracy for her psychological problems. (EX 28, p.3). Claimant was depressed over the loss of her husband, her daughter's actions in having her committed and her inability to get a job because she was a "liability." *Id*. On September 7, 2000, Dr. Tracy diagnosed claimant with anxiety, depression, substance abuse and personality disorder. *Id*. By letter, dated February 22, 2001, Dr. Tracy opined that Claimant's psychiatric illnesses was unrelated to her injury of October 10, 1996 based on a reasonable medical certainty. *Id*. at 8.

C(8) Medical Records of Dr. Maggio

Dr. Maggio issued a independent psychiatric evaluation on September 28, 2000. (EX 29, p.1). After reviewing medical reports from 1975 to February 2000, Dr. Maggio observed that her psychiatric history demonstrated "myriads of complaints basically surrounding Depression, Personality Disorder, Polysubstance Abuse, chaotic lifestyle with dysfunctional marriages which seem today to be causing her problems." *Id*. at 3. Dr. Maggio further stated:

> In no way does any of this aspect have any connection to the 10-10-96 injury. This 10-10-96 injury did not cause, exacerbate or aggravate the psychiatric conditions. They are two, separate entities. We see from a review of all her records that the first part of this report dealing with the injury 10-10-96 was treated as a completely separate entity where no psychiatric symptomatology is presented, no treatment is given and there is a complete return to work having reached MMI on 1-28-97. We also see a history that is a separate entity in her life in which her personality disorder and her chaotic lifestyles bring her into conflict with society, so there's no cause and effect relationship with the injury of 10-10

-96. It did not cause, it did not exacerbate, and it did not aggravate, nor does it lead to any psychiatric disability that might be causally related in any way to the 10-10-96 injury.

Id. at 4.

Dr. Maggio also issued a second opinion psychiatric evaluation on November 20, 2000, in which he reiterated that her workplace accident of October 10, 1996, was not at all related to her psychological problems. *Id*. at 11.

IV. DISCUSSION

A. Contention of the Parties

Claimant contends that in addition to injuring her shoulder in the October 10, 1996, workplace accident, she also injured her back as is evident by a bulge in her L5 disc. (Tr.10). Also, Claimant contends that her back pain prohibits her from sustained employment and that she became addicted to pain killers which caused subsequent mental and physical hospitalizations. (Tr.11). Accordingly, Claimant seeks entitlement to compensation for a total loss of wage earning capacity and medical benefits. (Tr. 12).

Employer contends that neither Claimant's back nor psychological conditions are causally related to the injury sustained on October 10, 1996. (E. PH Br. at 20). Furthermore, Employer asserts that the nature and extent of Claimant's alleged disability does not result in an incapacity to earn wages. *Id*. at 28-33. In the Alternative Employer asserts that if Claimant is entitled to any disability, such disability should be partial and not total in nature. *Id*. at 33.

B. Credibility of Parties

It is well-settled that in arriving at a decision in this matter the finder of fact is entitled to determine the credibility of the witnesses, to weigh the evidence and draw his own inferences from it. *Banks v. Chicago Grain Trimmers Association, Inc.*, 390 U.S. 459, 467, *reh. denied*, 391 U.S. 929 (1968); *Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce*, 661 F.2d 898, 900 (5th Cir. 1981); *Todd Shipyards Corporation v. Donovan*, 300 F.2d 741, 742 (5th Cir. 1962). A claimant's discredited and contradicted testimony is insufficient to support an award. *Director, OWCP v. Bethlehem Steel Corp.*, 620 F.2d 60, 64-65 (5th Cir. 1980); *Mackey v. Marine Terminals Corp*., 21 BRBS 129, 131 (1988); *Sylvester v. Bethlehem Steel Corp.*, 14 BRBS 234, 236 (1981).

Here I find that Claimant is not a credible witness. Among the numerous inconsistencies in the record I note that Claimant consistently misrepresented her educational level in employment applications. (EX 1, 16, 20, Tr. 61-66). Claimant gave inconsistent stories in relation to the onset of her back pain. (EX 14, p.1-4; Tr. 77). Claimant flatly denied ever seeing a doctor who issued a medical report concerning her condition and who stated in that report that he spoke with her. (EX 13, p.1; Tr. 80). Claimant lied

about her physical and mental condition in a post-injury report conducted by Employer, (EX 15; Tr. 88), and neglected to tell Dr. McCloskey about previous injuries to her back. (EX 21, p.10). Also, Claimant wrongfully denies that she abuses illegal drugs even though Claimant was hospitalized for a drug overdose in 1999, and on numerous occasions Claimant tested positive for the presence of illegal drugs. (Tr.87; EX 19, p.8-13; 23, p.3; 24; CX (drug tests on 7/01/99 and 2/28/00)). Furthermore, Claimant neglected to reveal post-injury employments in discovery, (EX 32, p.9), and lied in her deposition about not having previous back injuries. (EX 30, p.49). I also note that on September 7, 2000, her psychiatrist, Dr. Tracy, noted that Claimant did not give a reliable history and diagnosed acute psychosis with a working assessment of bi-polar disorder or schizo-affective disorder - maniac type. (CX).

C. Causation

Section 20 provides that "[i]n any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary - - (a) that the claim comes within the provisions of this Act." 33 U.S.C. § 920(a) (2000); *Kubin v. Pro-Football, Inc.*, 29 BRBS 117, 119 (1995); *Addison v. Ryan Walsh Stevedoring Co.*, 22 BRBS 32, 36 (1989); *Leone v. Sealand Terminal Corp.*, 19 BRBS 100, 101 (1986). To rebut the Section 20(a) presumption, the Employer must present substantial evidence that a claimant's condition is not caused by a work accident or that the work accident did not aggravate clamant's underlying condition. *Port Cooper/T Smith Stevedoring Co. v. Hunter*, 227 F.3d 285, 287 (5th Cir. 2000); *Gooden v. Director, OWCP*, 135 F.3d 1066, 1068 (5th Cir. 1998). Under the aggravation rule, an entire disability is compensable if a work related injury aggravates, accelerates, or combines with a prior condition. *Independent Stevedore Co. v. O'Leary*, 357 F.2d 812, 814-15 (9th Cir. 1966); *Kubin*, 29 BRBS at 119.

C(1) Prima Facie Case

To establish the right to invoke the Section 20(a) presumption, Claimant must show that he suffered some harm or pain as a result of a work related accident or as a result of working conditions. *Conoco, Inc., v. Director, OWCP*, 194 F.3d 684, 687 (5th Cir. 1999); *Merril v. Todd Pacific Shipyards Corp.*, 25 BRBS 140, 144 (1991).

Here, it is undisputed that Claimant suffered a workplace accident on October 10, 1996, when she fell after slipping on some false decking. (Tr. 23-25). Also undisputed is the fact that Claimant was acting in the course and scope of her employment. (JX 1). Likewise, the conditions of her employment are such that her repetitive bending, stooping, kneeling and climbing could cause a back injury. (Tr. 23). Claimant also asserts that her psychological problems stem from her addiction to pain medication that was prescribed to her after the accident, and asserts that the constant pain in her back prohibits her from gaining sustained employment which contributes to her depression. Accordingly, Claimant has established that she suffered a workplace accident and established that she suffered some harm as a result of that accident entitling her to the Section 20 presumption.

C(2) Rebuttal of the Presumption

"Once the presumption in Section 20(a) is invoked, the burden shifts to the employer to rebut it through facts - not mere speculation - that the harm was not work-related." *Conoco, Inc.*, 194 F.23d at 687-88 (citing, *Bridier v. Alabama Dry Dock & Shipbuilding Corp.*, 29 BRBS 84 (1995)); *Hampton v. Bethlehem Steel Corp.*, 24 BRBS 141, 144 (1990); *Smith v. Sealand Terminal*, 14 BRBS 844 (1982). The Fifth Circuit further elaborated:

> To rebut this presumption of causation, the employer was required to present *substantial evidence* that the injury was not caused by the employment. When an employer offers sufficient evidence to rebut the presumption--the kind of evidence a reasonable mind might accept as adequate to support a conclusion-- only then is the presumption overcome; once the presumption is rebutted it no longer affects the outcome of the case.

Noble Drilling v. Drake, 795 F.2d 478, 481 (5th Cir. 1986) (emphasis in original). *See also, Conoco, Inc., v. Director, OWCP*, 194 F.3d 684, 690 (5th Cir. 1999)(stating that the hurdle is far lower than a "ruling out" standard).

Here Employer has presented substantial evidence that Claimants back and psychological injuries are not work related and has rebutted the Section 20 presumption. Employer introduced the report of Dr. Rutledge who opined on December 6, 1996, that he did not connect Claimant's back pain with her fall, and that "it would be extremely unusual to have sustained a significant back injury with no mention of back pain for a period of two weeks after her injury." (EX 14, p.3). Also after reviewing Claimant's medical records, Dr. McCloskey, on August 7, 1999, and Dr. Hudson, on September 27, 2000, both concluded that Claimant's back pain was not related to her employment injury. (EX 21, p.8; EX 13, p.2).

Additionally, Employer introduced reports psychiatrist, Dr. Tracy, dated February 22, 1999, stating that Claimant psychological disability was not causally related to her workplace accident on October 10, 1996. (EX 28, p.8). Likewise, Dr. Maggio, who rendered an independent psychiatric evaluation on September 28, 2000, and who issued a second opinion on November 20, 2000, concluded that Claimant's psychological condition was not causally related to her workplace accident. (EX 29, p.4,11). Therefore, Employer has presented substantial evidence to rebut the Section 20 presumption and the issue of causation must be decided based on the record as a whole.

C(3) Causation on the Basis of the Record as a Whole

Once the employer offers sufficient evidence to rebut the Section 20(a) presumption, the claimant must establish causation based on the record as a whole. *Noble Drilling Co. v. Drake*, 795 F.2d 478, 481 (5th Cir. 1981). If, based on the record, the evidence is evenly balanced, then the employer must prevail. *Director, OWCP v. Greenwich Colleries*, 512 U.S. 267, 281 (1994).

C(3)(i) Pre-Accident Medical and Psychological Conditions

C(3)(i)(a) Back Injury

On September 10, 1975, Dr. Enger issued a report relating that Claimant suffered a back injury on July 10, 1975. (EX 11, p.1). A physical examination revealed that hyperextension caused her some difficulty, and Claimant was treated with oral medication. *Id*. On September 2, 1975, Claimant came back to Dr. Enger, who noted no change in a physical examination, but, noted that a x-ray revealed slight narrowing of the disc space at L5-S1. *Id*. Dr. Enger, however, found very little wrong and felt that Claimant could return to work. *Id*.

On July 17, 1992, Dr. Enger issued a consultative report regarding Claimant's 1992 back injury with BOH Brothers. A physical examination revealed a slight prominence of the right paravertebral muscle but not a true spasm. *Id*. at 45. Again Claimant had difficulty with hyperextension, and Claimant complained of pain when rolling her legs. *Id*. A routine x-ray was normal and Dr. Enger released Claimant to return to work with minor restrictions. *Id*. A few weeks later, however, Claimant returned with complaints of low back pain and an MRI showed that the L5 disc had moderate desiccation and mild bulging, but, no actual disc herniation or complication was present. *Id*. at 46-47.

On October 3, 1994, Dr. McDowell also treated Claimant for low back pain that arose when Claimant was wrestling with her boyfriend. *Id*. at 50. Dr. McDowell diagnosed low back strain and prescribed pain medication, and indicated that she should feel better within three days.

C(3)(i)(b) Psychological Injury

A consultation report by psychiatrist Dr. Else Tracy dated October 10, 1981, revealed that Claimant was "anxious and felt to be depressed and apparently [had] been having suicidal thoughts." *Id*. at 9. Claimant was treated for personal, marital, and family difficulties; and Dr. Tracy thought that Claimant may have a personality disorder or an underlying thought disorder. *Id*. Also, on November 7, 1985, Dr. Nicholls opined that Claimant suffered from depression, *Id*. at 19, and on March 5, 1987 Claimant was admitted to the hospital with severe depression and anxiety in relation to family and financial difficulties. *Id*. at 33. Clamant's mental state did not improve and Claimant was again hospitalized and treated by Dr. Tracy on July, 1987, after she threatened to commit suicide. *Id*. at 35. Dr. Tracy also noted a strong tendency to abuse medicines and alcohol with her drug abuse being iatrogenic. *Id*.

C(3)(ii) The Workplace Injury

Claimant was working near false decking, an area containing electrical hardware under panels in the bottom of the ship's deck. (Tr. 23-24). At the time she was injured one of the panels was missing, which required Claimant to step across a pitfall in the deck. (Tr. 24). When Claimant attempted to do so, she fell, testifying:

A: When I fell, one leg was on - - one up in the air, one foot was under the angle, my shoulder was under a - - when I hit and hit the steel deck, straight on my butt, like that. . . . And the only angle that I would have struck is the angle to the shoulder.

Q: So you hit your shoulder?

A: I hit my left shoulder, but the first thing that hit was my butt on the steel.

Q: Did you have any pain in your back?

A: The lower back.

(Tr. 25).

This injury took place on October 10, 1996, however, Claimant did not report the injury or seek medical treatment until October 21, 1996. (EX 3). The injury report relates that Claimant fell backwards and hit her shoulder. *Id*. Employer's infirmary reports detail that Claimant experienced pain in her left shoulder. (EX 12). Claimant related to Dr. Rutledge on December 6, 1996, that her back pain is "aggravated by sitting, by standing any period of time, by walking, and by excess activity," and by the end of every day she is "crying." (EX 14, p.4).

C(3)(iii) Present Conditions

C(3)(iii)(a) Present Physical Conditions

On December 6, 1996, Dr. Rutledge. conducted a physical exam and discovered that hyperextension was "uncomfortable" for Claimant and he found that Claimant's L5-S1 interspinous ligament and superior gluteal nerve were tender. (EX 14, p.3). Dr. Rutledge further opined that it was possible that Claimant sustained a "lumbosacral sprain with a contusion. *Id*. By December 13, 1996, Dr. Rutledge informed Claimant that there was no reason for her back to hurt, that she just had a sprain, and told her that the more active she was the faster it would clear. *Id*. After continuing complaints of back pain Dr. Rutledge conducted an MRI scan of Claimant's back on January 28, 1997, which reveled mild degenerative changes at the L5-S1 disc without herniation or neural impairment. *Id*.

On March 9, 1999, Dr. Westbrook conduced a physical examination of Claimant's back, but, the examination revealed no problems. (EX 18, p.14). Dr. Westbrook ordered a second physical test on May 3, 2000, and that test revealed that Claimant's lumbar flexation was limited to 90% of full range of motion and lumbar extension was limited to 75%. *Id*. Also, Claimant had a "pelvic movement dysfunction with a restrictive barrier into right innominate posterior translation and a hypomobility noted at L4-5 with active movements." *Id*. Treatment consisted of energy mobilization, heat and postural education. *Id*. at 20.

On June 16, 1999, Dr. McCloskey noted that an MRI showed degenerative bulging at the L5 disc, and that a bone scan performed by Dr. Rutledge was unremarkable. (EX 21, p.1) A physical exam revealed that Claimant could bend symmetrically at the waist and that there was some tenderness in the region of the SI joints bilaterally. *Id*. Dr. McCloskey diagnosed chronic post-traumatic low back syndrome with a degenerative and bulging L5 disc. *Id*. at 2. An August 1999 MRI of Claimant's pelvis and hips came back as reading normal, and an MRI of the lumbar spine produced a small central protrusion of the L5-S1 disc with minimal spinal stenosis but with no root compromise. *Id*. at 4.

C(3)(iii)(b) Present Mental Condition

In April 1998, Claimant's son died in an auto accident. (Tr. 31). On October 21, 1998, Claimant visited Dr. Westbrook about concerned about depression due to the loss of her son, marital, financial, and job related problems. (EX 18, p.5). Dr. Westbrook diagnosed severe depression, anxiety and coping difficulties, and opined that Claimant was totally disabled. *Id*. at 4, 9. In late June of 1999, Claimant attempted suicide. (Tr.46; EX 19, p.7).

In February 2000, Claimant was placed in a mental institution by her daughter and a Mississippi court in relation to threats of suicide. (EX 23, p.1). Dr. Deal, a psychiatrist, stated that causes for Claimant's admittance were that: her daughter does not show enough interest in her, drug abuse which Claimant denied, and marital discord. *Id*. Dr. Deal's diagnostic impression was chronic dysthymia, personality disorder with borderline antisocial and narcissistic traits. *Id*. at 2. On a drug test, Claimant tested positive for benzodiazepine and cannabinoids. *Id*. at 3. On the date Dr. Deal discharged Claimant he noted that she was in strong denial about the extent of her chemical dependancy problem, and was accepting very little responsibility for her problems, behavior and the related consequences. *Id*. at 7.

On June 14, 2000, Claimant again came under the care of Dr. Tracy for her psychological problems. (EX 28, p.3). Claimant was depressed over the loss of her husband, her daughter's actions in having her committed and her inability to get a job because she was a "liability." *Id*. On September 7, 2000, Dr. Tracy diagnosed claimant with anxiety, depression, substance abuse and personality disorder. *Id*. Dr. Tracy further opined that Claimant had acute psychosis and gave a working assessment of a bipolar disorder or schizo-affective disorder - maniac type. (CX - Report dated 9/7/00).

C(iv) Distinguishing Past and Present Impairments

Based on the record as a whole there is nothing to distinguish Claimant' pre-injury physical condition to her physical condition after the workplace injury. Similarly, no evidence connects Claimant's psychological disability to her slip and fall at work. Most notably, the x-ray and MRI scans taken of Claimant's lumbar region in 1975, 1992, 1997, and 1999 reveal the following:

1975 - X-ray revealed narrowing disc at L5-S1, but, very little wrong.. (EX 11, p.1)

1992 - MRI revealed L5 disc had moderate desiccation and mild bulging, but, no disc herniation or complication. (EX 11, p.46-47).

1996 - Workplace accident.

1997 - MRI revealed mild degenerative changes at L5-S1 disc without herniation or neural impairment. (EX 14, p.11)

1999 - MRI revealed small central protrusion of the L5-S1 disc with minimal spinal stenosis, but, no root compromise. (EX 21, p.4).

Significantly, when Dr. McCloskey was shown prior medical records from Dr. Enger in relation to her 1975 and 1992 back injuries, Dr. McCloskey observed that his MRI scan in 1999 was virtually identical. (EX 21, p.10).

Likewise, a comparison of Claimant's psychological condition shows that Claimant suffered from anxiety and depression well before her workplace accident, (EX 11, p.9,19,33,34-35), and after her accident. (EX 18, p.4-9; EX 28, p.3). Notably, in relation to Claimant's chemical dependency, which she alleges is a cause of her current psychological impairment, Dr. Tracy noted in 1987 that Claimant's drug abuse was iatrogenic. *Id*. at 33. Thus, there seems to be little, if any, change in Claimant psychological state before the workplace injury on October 10, 1996 and after that injury, with the exception of the traumatic event of her son's death.

C(v) Causal Connection

In relation to Claimant's back injury, no doctor has specifically related the back problems to her workplace accident. Indeed, Claimant did not even report the injury until eleven days later and then she only complained of shoulder pain. (EX 3). Her treating physician Dr. Rutledge, who met with her about a month after the accident, opined that it would be "extremely unusual to have sustained a significant back injury with no mention of back pain for two weeks after her injury." (EX 14, p.3). I also note that Drs. McCloskey and Dr. Hudson both issued uncontradicted medical reports concluding that Claimant's back pain was not related to her employment injury. (EX 21, p.8; EX 13, p.2). Furthermore, I find that Claimant's testimony relating that the onset of back pain was immediate, but, became worse over time, is not credible. Also, I note that Drs. Hudson, Rutledge, Westbrook and McCloskey could find no concrete medical basis for Claimant's subjective complaints of pain. Therefore, Employer has shown by a preponderance of the evidence that Claimant's back condition is not causally related to her workplace accident on October 10, 1996.

Regarding a causal link between Claimant's workplace accident and her psychological disability, it is significant that at no time between the workplace accident on October 10, 1996 and the death of her son in April 1998, did Claimant seek psychological treatment. (Tr. 101-03). The vast majority of

Claimant's psychological problems stem from the loss of her son, marital, family and financial difficulties. In 1999 Dr. Westboro diagnosed depression, anxiety and coping difficulties in relation to the loss of her son. (EX 18, p.4). In February 2000, Dr. Deal stated that causes for claimant's admittance were relationship problems, and marital discord as well as drug abuse. (EX 23, p.1). Similarly, Dr. Tracy treated Claimant for depression over the loss of her husband, relationship difficulties with her daughter, and her feelings in regards to her inability to work. (EX 28, p.3). Also, the record contains only the uncontradicted reports of Drs. Tracy and Maggio that Claimant's condition is not causally related to the workplace accident. Her psychological condition before the workplace injury id nearly identical to her psychological condition after the injury. Therefore, based on the record as a whole, Employer has shown that Claimant's psychological impairments are not causally related to the workplace accident.

V. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law and upon the entire record, I enter the following Order:

Claimant's petition for benefits under the Act is **DENIED** for failure to establish that the workplace injury caused her present impairments.

SO ORDERED.

A
RICHARD D. MILLS
Administrative Law Judge